Editorials

Medical leadership and general practice:

seductive or dictatorial?

Leadership has become fashionable in health services around the world. The National Health Service (NHS) has led the way with a Medical Leadership Competency Framework jointly developed by the NHS Institute of Innovation and Improvement and the Academy of Medical Royal Colleges in 2010, with the intention of embedding it in undergraduate and postgraduate curricula. According to Warren and Carnall:

'*It is indisputable that to deliver high-quality care consistently to patients requires, among many other factors, good medical leadership*'.[1]

Yet the empirical evidence for the importance of 'leadership' as a distinct characteristic is thin,[2] and the return on investment in leadership training programmes remains largely unmeasured worldwide.[3] A systematic review of the evidence about leadership says politely: *'the concept of leadership ... seems not to be fully developed'*.[4] A more recent international review of leadership styles, models, and theories, found health services leadership could be evaluated as *'transformational'*, *'situational'*, *'servant–leader relationship'*, or *'authentic'*.[5] Less common styles were *'quantum'* (reflective), *'charismatic'*, *and 'clinical'*. The plethora of leadership styles suggests that medical leadership has multiple meanings, including the 'informal leadership' observed in some Clinical Commissioning Groups.[6]

THE BADGE OF LEADERSHIP

Why, then, has the variously defined idea of medical leadership become so prominent in policy debates in the NHS? And what does medical leadership mean for GPs facing absorption into trusts, sustainability and transformation plans, accountable care organisations, primary care homes, and other burgeoning institutional forms?

In a *BJGP* editorial in 2012, four GP educators described the difficulty of embedding learning about leadership into GP training, warning that leadership could simply become: '*a badge that doctors wear, rather than a way of being, in which they believe*'.[7] They also commented on the irony of prominence being given to leadership: *'just at the time that the opportunities for self-direction are diminishing'*,[7] but they did not pursue this idea for fear of being thought cynical.

> *"A systematic review of the evidence about leadership says politely: 'the concept of leadership ... seems not to be fully developed'."*

They were right to be sceptical about the depth of leadership training, in our view, but could have pursued the paradox usefully. Our experiences of working with GPs on research and development projects since the fund-holding period, suggest to us, that leadership qualities may be relatively common at practice level, but not widespread in the evolving structures of NHS primary care. Two examples highlight the limited purchase of leadership in general practice. A survey of GPs in one county, in 2007, found limited leadership behaviours that matched a limited culture of innovation in the practices.[8] Apart from clinical audits and significant event analyses, quality improvement methods were not adopted by most responding practices. The authors concluded that practices needed support to enhance leadership skills, encourage innovation and develop quality improvement skills, to accelerate practice development, while noting that professionalised organisations, like practices, are less capable of breaking away from established organisational patterns.

Almost a decade later, in 2016, an analysis of GP federations (and similar entities like 'super practices') covering 41 million patients in England revealed 'a lack of ambition and priorities'.[9] Although there were common themes across the federations, like outcomes, 7-day working and clinical governance, the commonest theme was 'no plan'. Yet the leadership tasks in primary care were by then clear: to show and promote a clear sense of purpose, to motivate teams and to improve system performance.[10] The General Medical Council's (GMC) guidance on leadership and management for doctors published in 2012 added operational detail to these tasks, including working with colleagues, maintaining and improving standards of care, and planning, using and managing resources.[11]

> *"... leadership qualities may be relatively common at practice level, but not widespread in the evolving structures of NHS primary care."*

A SOCIOLOGICAL PERSPECTIVE

We think it may help to consider this poorly developed idea of medical leadership from a sociological perspective, outside the clinical disciplines and managerial thinking of the NHS. Medical leadership may not be a set of activities (like those in the GMC 2012 briefing[11]) at all, but rather an optimistic discourse[12] which co-opts a critical mass of practitioners to support NHS policy aims. In this policy construction of leadership, visions and values are owned by leaders, informed by patients, and delivered by staff.

To achieve policy aims medical leaders reconcile paradoxes, resolve uncertainties, and manage meaning.[13] The leadership discourse is a rhetorical device to engage practitioners, staff, and the public in NHS transformation, improvement in the quality of care, and increased efficiency and sustainability. It also mitigates the tension between a policy vision of a decentralised health service and the reality of centralised and intensifying performance management, partly by minimising dissent. The call for leadership turns the implementation of policy into everyone's responsibility, a common aim, and even one's sense of self. Rughani and colleagues[7] need not have feared the paradox they spotted; medical leadership and shrinking autonomy go hand-in-hand. Or perhaps they should have feared it more, because in a late

"… in a late modern society of autonomous individuals, management must be 'seductive as well as dictatorial'."

modern society of autonomous individuals, management must be 'seductive as well as dictatorial'.[12]

Our encounters with GPs suggest to us that some — perhaps most — have doubts about the current top-down recruitment drive for leaders, even though they see where clinical care needs to improve. Given the organisational flux and the rising workload pressures in general practice, it may be difficult to think through how medical leadership might emerge from below, supported by the informal yet influential leaders identified by Marshall and colleagues,[6] and to imagine what it would look like if it did. A first step might be to define medical leadership more precisely, and then to work out how to measure its impact in general practice on organisational change, quality of care, and sustainability.

Steve Iliffe,
Emeritus Professor of Primary Care for Older People, University College London, London.

Jill Manthorpe,
Professor of Social Work and Director of the NIHR Social Care Workforce Research Unit, Kings College London, London.

Provenance
Freely submitted; externally peer reviewed.

Competing interests
The views expressed in this article are those of the authors alone and should not be interpreted as those of the NIHR, the Department of Health and Social Care or the NHS.

DOI: https://doi.org/10.3399/bjgp19X700817

ADDRESS FOR CORRESPONDENCE

Steve Iliffe
Department of Primary Care and Population Health, University College London, Royal Free Campus, London, NW3 2PF, UK.

Email: s.iliffe@ucl.ac.uk

REFERENCES

1. Warren OJ, Carnall R. Medical leadership: why it's important, what is required, and how we develop it. *Postgrad Med J* 2011; **87(1023):** 27–32.
2. Wright BE, Pandey SK. Transformational Leadership in the public sector: does structure matter? *J Public Adm Res Theory* 2009; **20(1):** 75–89.
3. Jorm C, Parker M. Medical leadership is the new black: or is it? *Aust Health Rev* 2014; **39(2):** 217–219.
4. Reichenpfader U, Carlfjord S, Nilsen P. Leadership in evidence-based practice: a systematic review. *Leadersh Health Serv (Bradf Engl)* 2015; **28(4):** 298–316.
5. Carrara GLR, Bernardes A, Balsanelli AP, *et al*. Use of instruments to evaluate leadership in nursing and health services. *Rev Gaucha Enferm* 2017; **38(3):** e0060.
6. Marshall M, Holti R, Hartley J, *et al*. GP leadership in clinical commissioning groups: a qualitative multi-case study approach across England. *Br J Gen Pract* 2018; DOI: https://doi.org/10.3399/bjgp18X696197.
7. Rughani A, Godden A, Patterson D, Smithson H. Training for leadership. *Br J Gen Pract* 2012; DOI: https://doi.org/10.3399/bjgp12X616229.
8. Apekey TA, McSorley G, Tilling M, Siriwardena AN. Room for improvement? Leadership, innovation culture and uptake of quality improvement methods in general practice. *J Eval Clin Pract* 2011; **17(2):** 311–318.
9. Renaud-Komiya N. Exclusive: GP groups cover most of England but 'lack ambition and priorities'. *Health Services Journal* 2016; **6 Jan:** https://www.hsj.co.uk/primary-care/exclusive-gp-groups-cover-most-of-england-but-lack-ambition-and-priorities/7001120.article (accessed 16 Jan 2019).
10. Storey J, Holti R. *Towards a New Model of Leadership for the NHS*. NHS Leadership Academy, 2013.
11. General Medical Council. Leadership and management for all doctors. GMC, 2012. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/leadership-and-management-for-all-doctors (accessed 16 Jan 2019)
12. Martin GP, Learmonth M. A critical account of the rise and spread of 'leadership': the case of UK healthcare. *Soc Sci Med* 2012; **74(3):** 281–288.
13. Kempster S, Parry KW. Grounded theory and leadership research: a critical realist perspective. *Leadership Q* 2011; **22(1):** 106–120.